

**SHARED WORK PLAN APPLICATION****AGENCY USE ONLY
PLAN NO.****A. EMPLOYER INFORMATION**

1. Employer Name		2. Missouri Employer Account No.
3. Address (No., Street, or P.O. Box)		4. Telephone No. (Include Area Code)
City, State, ZIP Code		5. Affected Unit
6. Number of Workers	7. Number of Affected Workers	8. Plan to Reduce Hours By: From 20% To 40%
9. Select Method to Receive Biweekly List of Employees: <input type="checkbox"/> By Social Security No. <input type="checkbox"/> By Last Name (If the plan is approved, the employer must complete a biweekly certification. The forms will continue to be mailed to the employer for each week the plan is in effect.)		
10. Will reduction in hours affect participating employees' fringe benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please explain: _____ _____ _____		

B. EMPLOYER CERTIFICATION

I understand at least every two weeks during the time the Shared Work Plan is in effect, your office will mail a certification list of those employees in the affected unit. I will be responsible for completing our part of the form, and mailing the forms to your office. I certify that the implementation of this Shared Work Plan, and the resulting reduction in work hours is in lieu of temporary layoffs that would affect at least 10 percent of the affected unit.	
Employer or Representative	Title
Signature	Date

C. COLLECTIVE BARGAINING INFORMATION*(Complete only if the affected workers are members of a union.)*

Union Name	Local No.	Union Official	
Title of Official	Signature	Date	

FOR AGENCY USE ONLY – DO NOT COMPLETE BELOW THIS LINE

Employer Current: ☐ Yes ☐ No Initials _____ Date _____

Determinations: ☐ Denied ☐ Approved Beginning _____ Ending _____
(Mo., Day, Yr.) (Mo., Day, Yr.)

Reason for denial:

(Director)_____
(Date)